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In late syphilis the position is more obscure and, until the equivalent therapeutic values of penicillin, the arsenicals and bismuth have been determined more accurately, it will not be possible to utilize to the full the accumulated experience of the past 25 years. Meanwhile, as new preparations and dosage schemes are tried, it is to be hoped that the necessity for long and careful follow-up will be impressed upon both doctors and patients, and that propaganda will bring this to the notice of the public. As it has been rightly said (Moore): "We are still in the process of learning how to use this drug. We do not know yet and it is going to be some time before we are sure."

Conclusions

My own feelings on the subject can be summarized as follows.

(1) The management and treatment of late syphilis can never be a matter of routine. Ready-made schemes will not do; they must always be "made to measure".

(2) Syphilis, if possible, must not be allowed to spoil lives. Although inadequate treatment can do this, unnecessarily prolonged treatment can have the same result.

(3) The objects of treatment should be as follows.

(a) The healing of lesions, the relief of symptoms and the prevention of the transmission of infection.

(b) The maintenance of good health and the prevention of progression or relapse.

(c) Least important of all, serological reversal. If a patient can be maintained in or restored to health, sero-resistance can be regarded as something analogous to a positive Mantoux or Widal test in a patient recovering from tuberculosis or typhoid fever.

Although acknowledgments are not customary in an address such as this, it would be churlish not to acknowledge my indebtedness to my teachers, especially to my first teacher, Colonel Harrison who, many years ago, initiated me into the "art and mystery" of venereology; to the authors of the standard British and American text-books; to numerous writers of papers; and finally to my colleagues, both in the armed Forces and in civil life, who have helped me to make up my mind, at all events, on some aspects of this far from facile subject.

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CLINICAL RECORDS

BALANITIS XEROTICA OBLITERANS ASSOCIATED WITH CHRONIC GONORRHOEA

The following case report may be of interest in calling attention to a condition known to be pre-cancerous.

Case report

J. G., a British soldier, aged 33 years, single, gave the following medical history.

History.—In October 1945, he contracted gonorrhoea for the first time and was treated with 100,000 units of penicillin (20,000 units three-hourly) at a military hospital. He

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returned to duty after 2 days but was readmitted a month later with the diagnosis "gonorrhoea relapse". Again 100,000 units of penicillin were given. After temporary improvement, which lasted 8 days, the discharge returned. This time gonococci could not be detected on direct films and the prostate was apparently normal on examination. Urethral irrigations with potassium permanganate proved to be ineffective at first, with discharge and hazy urine persisting; but after 2 weeks the patient was symptom-free and left the hospital.

Observation and treatment.—Ten weeks later he was admitted to our centre with a fresh purulent urethral discharge. Gonococci were found on direct examination and in culture. There were no penile sores; the skin appeared to be healthy; the blood Khan reaction was negative. The patient had been circumcized in infancy. As no admission of sexual contact since October 1945 was obtained, the patient was thought to be suffering from a relapse of the original gonorrhoea. He received 300,000 units of penicillin (20,000 units three-hourly). Although the gonococcus disappeared during this treatment, a mucoid discharge and slight haze in the urine persisted.

A careful review of the case revealed three signs which had so far been overlooked. They were (1) a faded suprapubic scar, (2) a narrowed urinary meatus, and (3) a depigmented, almost white, hard area stretching from the meatus towards the fraenum.

The patient explained that some 4 years previously he had had a "stoppage of water" which, in the opinion of his surgeon, was caused by a urethral stricture. A cystotomy and urethral dilatation were then carried out successfully. The change in colour and texture of the glans penis had been noted by the patient, and he believed that this had preceded the retention of urine.

It was decided to explore the urethra with sounds, and with some difficulty a No. 5 gum-elastic bougie was passed. The greatest resistance was felt at the meatus and the immediately adjacent part of the urethra. After a week's gradual dilatation, a No. 16/20 curved sound could eventually be passed. During this time, 20 grammes of sulphathiazole had been administered. With full dilatation the discharge disappeared and the urine became clear. The patient was seen again during the following month and his condition appeared to be satisfactory. Unfortunately, he failed to report again.

Discussion

Apart from the gonorrhoea, which may have become chronic as a result of inadequate therapy and failure to recognize the stricture, the clinical picture of a stenosing meatus, together with the firm depigmented area on the glans penis, suggests balanitis xerotica obliterans.

Clinical picture of balanitis xerotica obliterans.—This condition was first described in 1928 by Stühmer¹, who believed that faulty circumcision could cause a chronic balanitis which eventually led to atrophic sclerosis. There is, however, little to support this view, seeing that a number of cases have been described with a long prepuce, often congenitally phimosed. Mota, reporting 4 cases, believes that a chronic and repeated balanoposthitis, made worse by a tight foreskin, may encourage the development of balanitis obliterans. If this theory be correct, timely circumcision might in fact prevent the progress of the disease.

Freeman and Laymon^{1 and 2} consider that the onset is commonly insidious, progressing to atrophic sclerosis of the glans with urethral stricture formation. Fissures and erosions are often present; haemorrhagic and serous bullae have also been noted. In patients who have not been circumcized, a characteristic dense sclerotic band is found some 1-2 centimetres from the free end of the foreskin.

Histologically the salient features are as follows: (1) hyperkeratosis with an atrophic epidermis; (2) some intracellular oedema in the lower parts of the epidermis; (3) most diagnostic of all, a homogeneous connective-tissue band in the upper part of the cutis with complete absence of elastic fibres. These two authors also draw attention to the fact that some patients exhibit plaques and papules of *lichen sclerosus et atrophicus* on the body. This finding is made more important by the close similarity of the histological pictures of both conditions.

There are a number of reports on the eventual development of carcinoma of the penis in patients suffering from balanitis obliterans (Stühmer^{1 and 2}; Frühwald; Grütz). Mota believes that kraurosis of the penis may be identical with the later stages of sclerosing balanitis.

Treatment.—There does not seem to be any effective treatment for the fully

developed condition. Regular observation of the patient to detect signs of malignancy is important in view of the pre-cancerous nature of the disease.

I believe that the small number of case reports, originating mainly from America and the Continent, does not constitute a true index of the occurrence of the condition and that, with greater diagnostic awareness, it might cease to be a clinical curiosity.

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Medical neglect and maltreatment in venereal disease

R. H. Oakley, writing in the number for 26th June 1946 of the *Medical Press and Circular*, deals roundly with the sins of omission and commission of the medical profession in the treatment of venereal disease. The former he ascribes to a psychological inhibition which prevents many medical men from studying venereal disease or from keeping the possibility in mind in making a diagnosis. It may also lead them to condone concealment on the part of their patients. Neglect—apart from simple failure to diagnose—may consist in undertreatment or delay in treatment, both leading to complications or to progression to secondary and later stages. Medical maltreatment includes such mistakes as incising a chancroidal bubo, using a preputial slit when circumcision is indicated, and the wrong use of instruments, particularly of large or insufficiently sharp needles.

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American Journal of Syphilis
Boletín medico-social
British Medical Journal
Crónica médica
Journal of the Cape Town Post-Graduate Medical Association
Journal of Experimental Medicine
Journal of Venereal Disease Information
Medical Times, New York
Medicina española
New England Journal of Medicine
Revista de la Asociación médica argentina
Revista del Instituto de Salubridad y Enfermedades tropicales
Revista médica de Chile
Revista médica de Yucatan
South African Journal of Medical Sciences
Urologic and Cutaneous Review